for payment. If you have a copy of your claim and the referring dentist's name is listed, please call Provider Relations (see *Key Contacts*) for a request to reprocess this claim.

2. Radiographs
   Radiographs should be taken only for clinical reasons as determined by the client's dentist. They should be of diagnostic quality and properly identified and dated. They are considered to be part of the client's clinical record.

   If additional panoramic films are needed for medical purposes (i.e: to check healing of a fractured jaw), they can be billed on an ADA form as long as it was done in an office setting. Otherwise, they should be billed on the CMS-1500 (formerly HCFA-1500) claim form using the CPT-4 code 70355 for panoramic x-ray.

3. Dental prophylaxis, fluoride treatment, and sealants
   Procedure code D1110 or D1205 will be allowed once every six months, and providers may bill for either code. Payment will **not** be made for both procedures within a six-month period. If providers are treating individuals with a developmental disability who require a prophylaxis treatment more often than six months intervals, write "handicapped" or "developmentally disabled" in box 31 or 38 on the ADA claim form.

   Sealants are limited to individuals age 20 and under, and are only allowed for a limited number of teeth (# 2, 3, 14, 15, 18, 19, 30, 31, A, J, K, & T). Retroactive review will be done to determine compliance with this policy.

4. Restoration
   For complete restoration of a tooth (filling of all surfaces currently damaged by caries), the following policies apply:

   - When more than one surface is involved, and one continuous filling is used, select the appropriate code from the range of D2110 through D2385.

   - When there are separate fillings on each surface, the one-surface codes are to be used, (D2110, D2140, D2330, D2380, D2385). Your records must clearly indicate each filling is treatment for a separate cavity.

   - The ADA views restorative work done on the same day and same tooth as one tooth with five surfaces.

     1. Only one payment will be allowed for each surface.

2. When more than one filling is included on a surface, combine the code. For example, MO and LO on a permanent molar restored in the same day should be coded as MOL. This should be coded this way whether the filling on the occlusal is a continuous filling or two separate fillings. The ADA views work done on the occlusal as one of the five surfaces that are billable.

3. When more than one filling is included on a surface and restored on different days, they should be coded on different days. For example if MO and LO on a permanent molar are restored on subsequent days, they should be coded as a MO on the first day and LO on the second day.

   If post payment review identifies erroneous payments made for additional fillings on the same surface as part of the same treatment, the over payments will be recovered.

- Amalgam restorations (including polishing)
  All adhesives (including amalgam bonding agents), liners, and base, are included as part of the restoration. If pins are used, they should be reported separately (see procedure code D2951).
- Silicate and resin restorations
  Resin refers to a broad category of materials including, but not limited to, composites. Also included may be bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. If pins are used, they should be reported separately.

5. Crowns
   Crowns are limited to situations where the tooth is periodontally healthy and without pulpal pathology and the tooth cannot be restored by any means other than a full coverage restoration. Crowns are covered only for clients with "Full" Medicaid coverage.

   Pre-fabricated crowns. Pre-fabricated stainless steel and resin crowns on all teeth are available for all clients, regardless of age. There is a limit of one per tooth, every five years.

   All other crowns. All other crowns are limited to clients ages 20 and under. Tooth colored full coverage crown restorations are only available for anterior teeth (6-11 and 22-27). Crowns on posterior teeth are limited to prefabricated resin and/or prefabricated stainless steel, except when necessary for partial denture abutments. Indicate in the "Remarks" section of the claim form which teeth are abutment teeth. Crowns are limited to one, per tooth, every five years.

Procedure Limits and Requirements

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D0120	Periodic oral exam	Allowed for adults every 6 months.	No
D0140	Limited oral exam – problem focused	Referral for a specific problem, emergencies, trauma or acute infections.	No
D0150	Comprehensive oral exam	This code is allowed for **new** clients of record for their initial visit.	No
D0210	Intraoral- complete series (including bitewings) (Minimum of 14 films)	• 1 film = 1 unit of service • Adults are allowed every 3 years. Call Provider Relations to verify if Medicaid has paid within the past 3 years. • Limit does not apply to those age 20 and younger.	No
D0270	Bitewing- single film	• Adults are limited to 4 films per year. • Limit does not apply to those age 20 and younger.	No
D0272	Bitewings - two films	• 2 films = 1 unit of service • Adults are limited to 4 films per year. • Limit does not apply to those age 20 and younger.	No
D0274	Bitewings - four films	• 4 films = 1 unit of service • Adults are limited to 4 films per year. • Limit does not apply to those age 20 and younger.	No
D0330	Panoramic film	• Adults are limited to one film every three years. • Limit does not apply to those 20 yrs & under.	No
D0340	Cephalometric film		Ages 20 and under only
D0350	Oral/facial images		Ages 20 and under only
D0460	Pulp vitality tests		Ages 20 and under only
D0470	Diagnostic models – also known as diagnostic casts or study models		Ages 20 and under only
D1110	Prophylaxis – adult	Allowed every 6 months.	No
D1205	Topical application of fluoride (including prophylaxis) – adult	Allowed every 6 months.	No
D1351	Sealant - per tooth	• # 2, 3, 14, 15, 18,19, 30, 31, A, J, K, T • Limited to individuals age 20 and under.	Ages 20 and under only

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D1510 - D1550	Space Maintainers		Ages 20 and under only
D2710 - D2799 D6720 - D6792	Non prefabricated Crowns	Limited to: • Clients with full Medicaid coverage • Anterior teeth (6-11 and 22-27) except when necessary for partial denture abutments • One per tooth every five years	Ages 20 and under only
D2930 - D2933	Prefabricated stainless steel and resin crowns	Limited to: • Clients with full Medicaid coverage • One per tooth every five years	No
D2951	Pin retention-per tooth, in addition to restoration	Maximum two units per tooth.	Ages 20 and under only
D3220	Therapeutic pulpotomy (excluding final restoration) Performed on primary or permanent teeth.	No additional fee will be paid for pulp capping or bases.	Ages 20 and under only
D3230	Pulpal Therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		Ages 20 and under only
D3240	Pulpal Therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	• For primary second molars (A, J, K, T). • Only allowed if 6 year Molar is not erupted or permanent second pre-molar is congenitally absent.	Ages 20 and under only
D3410 - D3426	Apicoectomy/Periradicular Services		Ages 20 and under only
D4210 & D4211	Gingivectomy or gingivoplasty (Per quadrant)	• Limited to cases involving gingival hyperplasia due to medication reaction or pregnancy. • Quadrants should be listed in the "**Tooth Number**" column as follows: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	Ages 20 and under only

Procedure Limits and Requirements (continued)
These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D4341 & D4342	Periodontal scaling and root planing (Per quadrant)	• 1 quadrant = 1 unit of service. • Providers are allowed to bill up to 4 quadrants every year. • Must scale and root plane at least 4 teeth per quadrant with documented pocket depths of at least 4 mm in the medical history file. • Allowed once per year. • Quadrants should be listed in the "**Tooth Number**" column as follows: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	No
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.	• To be used prior to periodontal scaling and root planing only if provider cannot determine extent of periodontal scaling and root planing without this procedure. • Limited to once per year if medically indicated.	No
D4910	Periodontal maintenance procedures	• To be used after initial periodontal scaling and root planing completed. • Limited to once every three months if medically indicated.	No
D5110	Complete upper	Call Provider Relations to verify if Medicaid has paid dentures within the past 10 years.	No
D5120	Complete lower	Call Provider Relations to verify if Medicaid has paid dentures within the past 10 years.	No
D5130	Immediate upper	• Includes limited follow-up care only. • Does not include required future rebasing/relining procedures.	No
D5140	Immediate lower	• Includes limited follow-up care only. • Does not include required future rebasing/relining procedures.	No
D5211	Maxillary partial denture – Resin Base (including any conventional clasps, rests and teeth)	• Includes acrylic resin base denture with resin or wrought iron clasps. • Partial dentures will only be replaced every 5 years.	No

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D5212	Mandibular partial denture – Resin Base (including any conventional clasps, rests and teeth)	• Includes acrylic resin base denture with resin or wrought iron clasps. • Partial dentures will only be replaced every 5 years.	No
D5213	Maxillary partial denture – Cast metal framework with resin denture bases	• Includes any conventional clasps, rests and teeth. • Partial dentures will only be replaced every 5 years.	No
D5214	Mandibular partial denture – Case metal framework with resin denture bases	• Includes any conventional clasps, rests and teeth. • Partial dentures will only be replaced every 5 years.	No
D5410	Adjust complete denture – upper	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5411	Adjust complete denture – lower	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5421	Adjust partial denture – upper	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5422	Adjust partial denture – lower	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5520	Replace missing or broken teeth – complete denture (each tooth).	Each additional tooth needs to be billed on separate lines with the tooth number indicated in the tooth number column.	No
D5610	Repair resin saddle or base	No teeth or metal involved.	No
D5710	Rebase complete upper denture (jump or duplicate)	Dentures must be 5 years old or older.	No

Procedure Limits and Requirements (continued)
These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D5711	Rebase complete lower denture (jump or duplicate)	Dentures must be 5 years old or older.	No
D5720	Rebase upper partial denture (jump or duplicate)	Dentures must be 5 years old or older.	No
D5721	Rebase lower partial denture (jump or duplicate)	Dentures must be 5 years old or older.	No
D5820 D5821	Interim partial denture (maxillary) Inerim partial denture (mandibular)	• Use of a flipper is considered a partial denture. • Partial dentures will only be replaced every 5 years.	Ages 20 and under only
D6210 - D6252	Bridges	Limited to: • Clients with full Medicaid coverage • Anterior teeth (6-11 and 22-27). See *9. Prosthodontics (fixed)* earlier in this chapter for additional limits.	Ages 20 and under only
D6720 - D6792 D2710 - D2799	Non prefabricated Crowns	Limited to: • Clients with full Medicaid coverage • Anterior teeth (6-11 and 22-27) except when necessary for partial denture abutments • One per tooth every five years	Ages 20 and under only
D7140	Extraction, erupted tooth or exposed root	Includes local anesthesia, suturing, if needed, and routine postoperative care.	No
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	No
D7220	Removal of impacted tooth – soft tissue	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.	No
D7230	Removal of impacted tooth – partially bony (crown of tooth is partially covered by bone)	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.	No

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D7240	Removal of impacted tooth – completely bony (crown of tooth is completely covered by bone)	Most or all of crown covered by bone; requires muco-periosteal flap elevation and bone removal.	No
D7250	Surgical removal of residual tooth roots (cutting procedure)	Includes cutting of soft tissue and bone, removal of tooth structure and closure.	No
D7310	Alveoloplasty in conjunction with extractions (Per quadrant)	Indicate quadrant in "**Tooth Number**" column: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	No
D7320	Alveoloplasty not in conjunction with extractions (Per quadrant)	Indicate quadrant in "**Tooth Number**" column: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	No
D7340	Vestibuloplasty – ridge extension	Secondary epithelialization.	Ages 20 and under only
D7350	Vestibuloplasty – ridge extension	Include soft tissue graft, muscle re-attachment, revision & management of tissue.	Ages 20 and under only
D7540	Removal of reaction-producing foreign bodies – musculosk-eletal system	May include, but not limited to, removal of splinters, pieces of wire etc., from muscle and/or bone.	No
D7550	Sequestrectomy for Osteomyelitis	Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.	No
D7911	Complicated suture – up to 5 cm	• Reconstruction requiring delicate handling of tissues and wide under-mining for meticulous closure. • Excludes closure of surgical incision.	No
D7912	Complicated suture – greater than 5 cm	• Reconstruction requiring delicate handling of tissues and wide under-mining for meticulous closure. • Excludes closure of surgical incision.	No
D7920	Skin graft	Identify defect covered, location, and type of graft.	Ages 20 and under only

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D7970	Excision of hyperplastic tissue, per arch	For edentulous client.	Ages 20 and under only
D9230	Nitrous Oxide		Ages 12 and under only
D9110	Palliative (emergency) treatment of dental pain – minor procedures	Writing prescriptions, occlusal adjustments, emergency examinations, and instructions for home care are not included.	No
D9241	IV Sedation (first 30 minutes)	May only be used if the client is physically or emotionally unable to undergo the proposed treatment or procedures using local anesthesia alone or in conjunction with oral sedation and/or nitrous oxide.	No
D9242	IV Sedation (each additional 15 minutes)	See limitations under procedure code D9241.	No
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	Includes specialist consultation; should not be reported to describe discussion of treatment plan.	No
D9410	House call (also used for nursing home visits)	One nursing home call per day even when multiple clients are seen.	No
D9420	Hospital call	• Code is to be used when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. • Code can only be billed one time per day even when multiple clients are seen, and one of the following conditions must be met: • The client is unable to be managed in the office or is medically unstable. • Medical necessity must be documented in the client file.	No
D9920	Behavior management Billed in 15 minute units (max 4 units per visit)	• 15 min = 1 unit of service. • Code can only be billed where an office treatment requires extraordinary effort and is the only alternative to general anesthesia. • Includes any and all pharmacological, psychological, physical management adjuncts required or utilized. • Limit of 12 units per year.	No

Date of service

Date of service is the date a procedure is completed. However, there are instances where Medicaid will allow a date other than the completion date.

If a denture is inserted during a month when the client is not eligible, but previous work (including laboratory work) was completed during an eligible period, the denture claim will be allowed to be billed using the impression date rather than the seating date as the date of service.

If a crown or bridge has been sent to the laboratory for final processing, and the client never shows for the appointment to have the final placement, providers may bill the date of service as the date the crown or bridge was sent to the laboratory for final processing. However, the client must have Medicaid eligibility at the time crown or bridge is sent to the lab. Crowns and bridges are limited to clients age 20 and under.

If a provider has opened the area for a root canal but anticipates the client will not return for completion or is referring client to another provider for root canal completion, procedure D3220 (covered for ages 20 and under only) may be billed. However, root canal codes must be billed to Medicaid at the time of completion.

Fee schedule

All procedures listed in the Montana Medicaid Fee Schedule are covered by the Medicaid program and must be used in conjunction with the limits listed in the previous section (*Procedure limits and requirements*). If CDT-4 codes exist and are not listed in the Montana Medicaid Fee Schedule, the items are not a covered service of the Medicaid program. Services that are not covered or exceed the specified limits can be billed to the client as long as the provider informs the client, prior to providing the services, that the client will be billed. Fee schedules are available on disk, hardcopy, or on the internet. For disk or hard copy, contact Provider Relations (see *Key Contacts*). The internet address for fee schedules is as follows:

www.dphhs.state.mt.us/hpsd/medicaid/medpi/medfs/medfs.htm

Calculating service limits

Service limits do not apply to individuals up to and including age 20.

Any service which is covered only at specified intervals for adults will have a notation next to the procedure code with information about the limit (refer to previous section *Procedure limits and requirements)*. When scheduling appointments, please be aware limits are controlled by our computerized claims payment system in this manner.